

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Minnie Lou AUSTIN			2a. DATE OF DEATH MONTH DAY YEAR July 9, 1983		2b. HOUR 8:50 ^{AM}
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9-27-1931		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Calvert MD.	
10. CITY OR TOWN OF DEATH Prince Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Calvert	13c. CITY OR TOWN Prince Frederick	
14. FATHER'S NAME Theron			15. MOTHER'S MAIDEN NAME Grace Boyd		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 227-44-9887		17. INFORMANT James Wm. Austin, Jr. same as #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac arrest.</i> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <i>diabetic & Hypertensive.</i> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Emad R. Al-Banna</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 1-9-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Emad R. Al-Banna, M.D.		22e. ADDRESS Prince Frederick, Maryland 20678	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 7-11-1983	23c. NAME OF CEMETERY OR CREMATORY Boyd Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Woolwine Patrick Virginia
24. FUNERAL DIRECTOR NAME Donald V. Borgwardt		25a. DATE REC'D. BY REGISTRAR JUL 13 1983	
ADDRESS Port Republic, Md. 20676		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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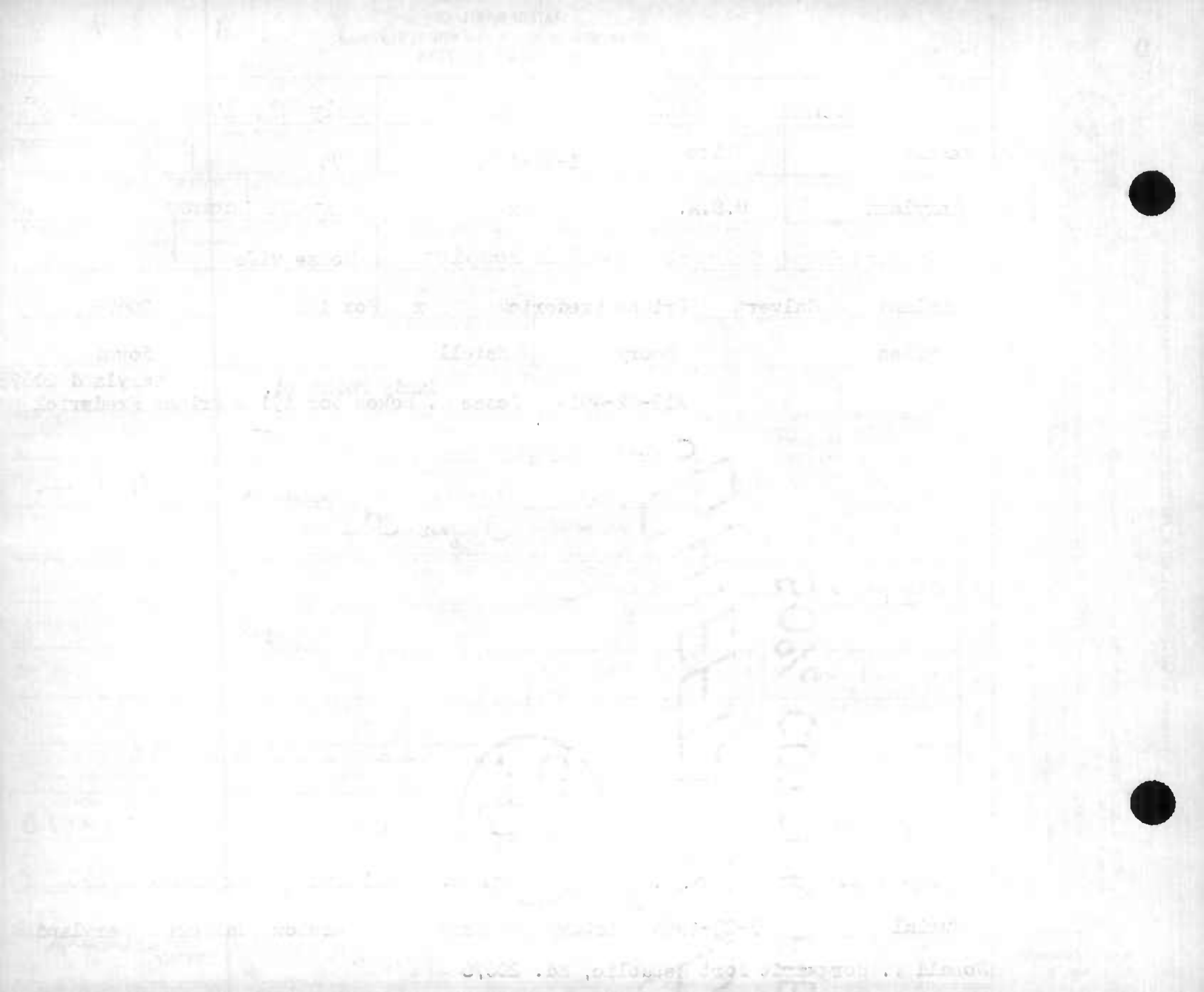
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ethel Hall BOWEN			2a. DATE OF DEATH MONTH DAY YEAR July 21, 1983			2b. HOUR A M 8:26				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1-24-1909		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Calvert County MD.				
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. COUNTY Calvert		13c. CITY OR TOWN Prince Frederick		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 186 20678	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Emory			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estell Bowen							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 219-42-4914		17. INFORMANT ADDRESS Sandy Point Rd. Maryland 20678 Jesse H. Bowen Box 191 E Prince Frederick					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Possible Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4 hrs.</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Complete Heart Block</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>7/21</u> 19 <u>83</u> , to <u>7/21</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>7/21</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE AT Munshi				DEGREE M.D.		ATTENDING MEDICAL STAFF PHYSICIAN DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/21/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anwar T. Munshi, M.D.				22e. ADDRESS Prince Frederick, Maryland 20678						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-23-1983		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Barstow Calvert Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS Donald V. Borgwardt Port Republic, Md. 20676				25a. DATE REC'D BY REGISTRAR JUL 28 1983		25b. REGISTRAR'S SIGNATURE John G. Galt				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 18840				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Faye Ellen Creighton				2a. DATE OF DEATH MONTH DAY YEAR July 12, 1983				2b. HOUR 6:00a M
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR October 9, 1946		6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Calvert MD.		
10. CITY OR TOWN OF DEATH Lusby		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Box 469 Rousby Hall Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Disabled		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Lusby		13e. STREET ADDRESS Box 469 Rousby Hall Rd 20657		
14. FATHER'S NAME FIRST MIDDLE LAST Alvin Creighton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Humphreys				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-78-8092		17. INFORMANT ADDRESS Virginia Creighton same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Aneurysm DUE TO, OR AS A CONSEQUENCE OF (b) Brain extension DUE TO, OR AS A CONSEQUENCE OF (c) Mediastinal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from June 23, 1983 , to 7-10-83 , that (I) (we) lost saw the deceased alive on 7-10-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Dr. Jamalouji				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-13-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMALOUJI. M.D.				22e. ADDRESS Prince Frederick, Maryland 20678				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-14-1983		23c. NAME OF CEMETERY OR CREMATORY Middleham Chapel cem		23d. LOCATION CITY OR TOWN COUNTY STATE Lusby Calvert Md.		
24. FUNERAL DIRECTOR NAME Donald V. Borgwardt				ADDRESS Port Republic, Md. 20676		25a. DATE REC'D. BY REGISTRAR JUL 18 1983		
						25b. REGISTRAR'S SIGNATURE John J. Canine		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

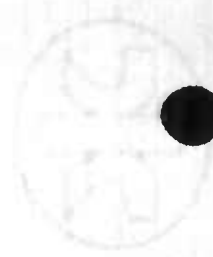
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 8 8 4 1	
1. FOR - STATE REGISTRAR				CERTIFICATE OF DEATH	
1. DECEASED NAME				2a. DATE OF DEATH	
FIRST MIDDLE LAST				MONTH DAY YEAR	
Tina Annette DEPHILLIP				July 27, 1983	
3. SEX		4. RACE		5. DATE OF BIRTH	
Female		White		MONTH DAY YEAR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
35 Maryland		USA		12 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		9. BALTIMORE CITY OR COUNTY OF DEATH	
59 Prince Frederick		Calvert Memorial Hospital		Calvert MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	
N/A		N/A		13a. STATE	
13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
35 MD		Calvert		13e. STREET ADDRESS	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
140 Michael		140 Mitzu L. Minkiff		16b. SOCIAL SECURITY NO.	
16c. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)		16d. SOCIAL SECURITY NO.		17. INFORMANT	
NO		N/A		17. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20a. AUTOPSY?	
3440 PART I. DEATH WAS CAUSED BY:		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
IMMEDIATE CAUSE (a) Cardiac & Respiratory arrest		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
DUE TO, OR AS A CONSEQUENCE OF		21a. TIME OF INJURY		21b. PLACE OF INJURY	
(b) Cerebral artery. Spasm		HOUR A.M. MONTH DAY YEAR		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
DUE TO, OR AS A CONSEQUENCE OF		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED	
(c) supination. Good physiologic		21e. PLACE OF INJURY		21f. INJURY OCCURRED	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a		21g. PLACE OF INJURY		21h. INJURY OCCURRED	
		21i. PLACE OF INJURY		21j. INJURY OCCURRED	
		21k. PLACE OF INJURY		21l. INJURY OCCURRED	
		21m. PLACE OF INJURY		21n. INJURY OCCURRED	
		21o. PLACE OF INJURY		21p. INJURY OCCURRED	
		21q. PLACE OF INJURY		21r. INJURY OCCURRED	
		21s. PLACE OF INJURY		21t. INJURY OCCURRED	
		21u. PLACE OF INJURY		21v. INJURY OCCURRED	
		21w. PLACE OF INJURY		21x. INJURY OCCURRED	
		21y. PLACE OF INJURY		21z. INJURY OCCURRED	
		21aa. PLACE OF INJURY		21ab. INJURY OCCURRED	
		21ac. PLACE OF INJURY		21ad. INJURY OCCURRED	
		21ae. PLACE OF INJURY		21af. INJURY OCCURRED	
		21ag. PLACE OF INJURY		21ah. INJURY OCCURRED	
		21ai. PLACE OF INJURY		21aj. INJURY OCCURRED	
		21ak. PLACE OF INJURY		21al. INJURY OCCURRED	
		21am. PLACE OF INJURY		21an. INJURY OCCURRED	
		21ao. PLACE OF INJURY		21ap. INJURY OCCURRED	
		21aq. PLACE OF INJURY		21ar. INJURY OCCURRED	
		21as. PLACE OF INJURY		21at. INJURY OCCURRED	
		21au. PLACE OF INJURY		21av. INJURY OCCURRED	
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		21ay. PLACE OF INJURY		21az. INJURY OCCURRED	
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		21bk. PLACE OF INJURY		21bl. INJURY OCCURRED	
		21bm. PLACE OF INJURY		21bn. INJURY OCCURRED	
		21bo. PLACE OF INJURY		21bp. INJURY OCCURRED	
		21bq. PLACE OF INJURY		21br. INJURY OCCURRED	
		21bs. PLACE OF INJURY		21bt. INJURY OCCURRED	
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		21by. PLACE OF INJURY		21bz. INJURY OCCURRED	
		21ca. PLACE OF INJURY		21cb. INJURY OCCURRED	
		21cc. PLACE OF INJURY		21cd. INJURY OCCURRED	
		21ce. PLACE OF INJURY		21cf. INJURY OCCURRED	
		21cg. PLACE OF INJURY		21ch. INJURY OCCURRED	
		21ci. PLACE OF INJURY		21cj. INJURY OCCURRED	
		21ck. PLACE OF INJURY		21cl. INJURY OCCURRED	
		21cm. PLACE OF INJURY		21cn. INJURY OCCURRED	
		21co. PLACE OF INJURY		21cp. INJURY OCCURRED	
		21cq. PLACE OF INJURY		21cr. INJURY OCCURRED	
		21cs. PLACE OF INJURY		21ct. INJURY OCCURRED	
		21cu. PLACE OF INJURY		21cv. INJURY OCCURRED	
		21cw. PLACE OF INJURY		21cx. INJURY OCCURRED	
		21cy. PLACE OF INJURY		21cz. INJURY OCCURRED	
		21da. PLACE OF INJURY		21db. INJURY OCCURRED	
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		21dg. PLACE OF INJURY		21dh. INJURY OCCURRED	
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		21do. PLACE OF INJURY		21dp. INJURY OCCURRED	
		21dq. PLACE OF INJURY		21dr. INJURY OCCURRED	
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		21eq. PLACE OF INJURY		21er. INJURY OCCURRED	
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		21ey. PLACE OF INJURY		21ez. INJURY OCCURRED	
		21fa. PLACE OF INJURY		21fb. INJURY OCCURRED	
		21fc. PLACE OF INJURY		21fd. INJURY OCCURRED	
		21fe. PLACE OF INJURY		21ff. INJURY OCCURRED	
		21fg. PLACE OF INJURY		21fh. INJURY OCCURRED	
		21fi. PLACE OF INJURY		21fj. INJURY OCCURRED	
		21fk. PLACE OF INJURY		21fl. INJURY OCCURRED	
		21fm. PLACE OF INJURY		21fn. INJURY OCCURRED	
		21fo. PLACE OF INJURY		21fp. INJURY OCCURRED	
		21fq. PLACE OF INJURY		21fr. INJURY OCCURRED	
		21fs. PLACE OF INJURY		21ft. INJURY OCCURRED	
		21fu. PLACE OF INJURY		21fv. INJURY OCCURRED	
		21fw. PLACE OF INJURY		21fx. INJURY OCCURRED	
		21fy. PLACE OF INJURY		21fz. INJURY OCCURRED	
		21ga. PLACE OF INJURY		21gb. INJURY OCCURRED	
		21gc. PLACE OF INJURY		21gd. INJURY OCCURRED	
		21ge. PLACE OF INJURY		21gf. INJURY OCCURRED	
		21gg. PLACE OF INJURY		21gh. INJURY OCCURRED	
		21gi. PLACE OF INJURY		21gj. INJURY OCCURRED	
		21gk. PLACE OF INJURY		21gl. INJURY OCCURRED	
		21gm. PLACE OF INJURY		21gn. INJURY OCCURRED	
		21go. PLACE OF INJURY		21gp. INJURY OCCURRED	
		21gq. PLACE OF INJURY		21gr. INJURY OCCURRED	
		21gs. PLACE OF INJURY		21gt. INJURY OCCURRED	
		21gu. PLACE OF INJURY		21gv. INJURY OCCURRED	
		21gw. PLACE OF INJURY		21gx. INJURY OCCURRED	
		21gy. PLACE OF INJURY		21gz. INJURY OCCURRED	
		21ha. PLACE OF INJURY		21hb. INJURY OCCURRED	
		21hc. PLACE OF INJURY		21hd. INJURY OCCURRED	
		21he. PLACE OF INJURY		21hf. INJURY OCCURRED	
		21hg. PLACE OF INJURY		21hh. INJURY OCCURRED	
		21hi. PLACE OF INJURY		21hj. INJURY OCCURRED	
		21hk. PLACE OF INJURY		21hl. INJURY OCCURRED	
		21hm. PLACE OF INJURY		21hn. INJURY OCCURRED	
		21ho. PLACE OF INJURY		21hp. INJURY OCCURRED	
		21hq. PLACE OF INJURY		21hr. INJURY OCCURRED	
		21hs. PLACE OF INJURY		21ht. INJURY OCCURRED	
		21hu. PLACE OF INJURY		21hv. INJURY OCCURRED	
		21hw. PLACE OF INJURY		21hx. INJURY OCCURRED	
		21hy. PLACE OF INJURY		21hz. INJURY OCCURRED	
		21ia. PLACE OF INJURY		21ib. INJURY OCCURRED	
		21ic. PLACE OF INJURY		21id. INJURY OCCURRED	
		21ie. PLACE OF INJURY		21if. INJURY OCCURRED	
		21ig. PLACE OF INJURY		21ih. INJURY OCCURRED	
		21ii. PLACE OF INJURY		21ij. INJURY OCCURRED	
		21ik. PLACE OF INJURY		21il. INJURY OCCURRED	
		21im. PLACE OF INJURY		21in. INJURY OCCURRED	
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		21iq. PLACE OF INJURY		21ir. INJURY OCCURRED	
		21is. PLACE OF INJURY		21it. INJURY OCCURRED	
		21iu. PLACE OF INJURY		21iv. INJURY OCCURRED	
		21iw. PLACE OF INJURY		21ix. INJURY OCCURRED	
		21iy. PLACE OF INJURY		21iz. INJURY OCCURRED	
		21ja. PLACE OF INJURY		21jb. INJURY OCCURRED	
		21jc. PLACE OF INJURY		21jd. INJURY OCCURRED	
		21je. PLACE OF INJURY		21jf. INJURY OCCURRED	
		21jg. PLACE OF INJURY		21jh. INJURY OCCURRED	
		21ji. PLACE OF INJURY		21jj. INJURY OCCURRED	
		21jk. PLACE OF INJURY		21jl. INJURY OCCURRED	
		21jm. PLACE OF INJURY		21jn. INJURY OCCURRED	
		21jo. PLACE OF INJURY		21jp. INJURY OCCURRED	
		21jq. PLACE OF INJURY		21jr. INJURY OCCURRED	
		21js. PLACE OF INJURY		21jt. INJURY OCCURRED	
		21ju. PLACE OF INJURY		21jv. INJURY OCCURRED	
		21jw. PLACE OF INJURY		21jx. INJURY OCCURRED	
		21jy. PLACE OF INJURY		21jz. INJURY OCCURRED	
		21ka. PLACE OF INJURY		21kb. INJURY OCCURRED	
		21kc. PLACE OF INJURY		21kd. INJURY OCCURRED	
		21ke. PLACE OF INJURY		21kf. INJURY OCCURRED	
		21kg. PLACE OF INJURY		21kh. INJURY OCCURRED	
		21ki. PLACE OF INJURY		21kj. INJURY OCCURRED	
		21km. PLACE OF INJURY		21kn. INJURY OCCURRED	
		21ko. PLACE OF INJURY		21kp. INJURY OCCURRED	
		21kq. PLACE OF INJURY		21kr. INJURY OCCURRED	
		21ks. PLACE OF INJURY		21kt. INJURY OCCURRED	
		21ku. PLACE OF INJURY		21kv. INJURY OCCURRED	
		21kw. PLACE OF INJURY		21kx. INJURY OCCURRED	
		21ky. PLACE OF INJURY		21kz. INJURY OCCURRED	
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		21lc. PLACE OF INJURY		21ld. INJURY OCCURRED	
		21le. PLACE OF INJURY		21lf. INJURY OCCURRED	
		21lg. PLACE OF INJURY		21lh. INJURY OCCURRED	
		21li. PLACE OF INJURY		21lj. INJURY OCCURRED	
		21lk. PLACE OF INJURY		21ll. INJURY OCCURRED	
		21lm. PLACE OF INJURY		21ln. INJURY OCCURRED	
		21lo. PLACE OF INJURY		21lp. INJURY OCCURRED	
		21lq. PLACE OF INJURY		21lr. INJURY OCCURRED	
		21ls. PLACE OF INJURY		21lt. INJURY OCCURRED	
		21lu. PLACE OF INJURY		21lv. INJURY OCCURRED	
		21lw. PLACE OF INJURY		21lx. INJURY OCCURRED	
		21ly. PLACE OF INJURY		21lz. INJURY OCCURRED	
		21ma. PLACE OF INJURY		21mb. INJURY OCCURRED	
		21mc. PLACE OF INJURY		21md. INJURY OCCURRED	
		21me. PLACE OF INJURY		21mf. INJURY OCCURRED	
		21mg. PLACE OF INJURY		21mh. INJURY OCCURRED	
		21mi. PLACE OF INJURY		21mj. INJURY OCCURRED	
		21mk. PLACE OF INJURY		21ml. INJURY OCCURRED	
		21mm. PLACE OF INJURY		21mn. INJURY OCCURRED	
		21mo. PLACE OF INJURY		21mp. INJURY OCCURRED	
		21mq. PLACE OF INJURY		21mr. INJURY OCCURRED	
		21ms. PLACE OF INJURY		21mt. INJURY OCCURRED	
		21mu. PLACE OF INJURY		21mv. INJURY OCCURRED	
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		21my. PLACE OF INJURY		21mz. INJURY OCCURRED	
		21na. PLACE OF INJURY		21nb. INJURY OCCURRED	
		21nc. PLACE OF INJURY		21nd. INJURY OCCURRED	
		21ne. PLACE OF INJURY		21nf. INJURY OCCURRED	
		21ng. PLACE OF INJURY		21nh. INJURY OCCURRED	
		21ni. PLACE OF INJURY		21nj. INJURY OCCURRED	
		21nk. PLACE OF INJURY		21nl. INJURY OCCURRED	
		21nm. PLACE OF INJURY		21nn. INJURY OCCURRED	
		21no. PLACE OF INJURY		21np. INJURY OCCURRED	
		21nq. PLACE OF INJURY		21nr. INJURY OCCURRED	
		21ns. PLACE OF INJURY		21nt. INJURY OCCURRED	
		21nu. PLACE OF INJURY		21nv. INJURY OCCURRED	
		21nw. PLACE OF INJURY		21nx. INJURY OCCURRED	
		21ny. PLACE OF INJURY		21nz. INJURY OCCURRED	
		21oa. PLACE OF INJURY		21ob. INJURY OCCURRED	
		21oc. PLACE OF INJURY		21od. INJURY OCCURRED	
		21oe. PLACE OF INJURY		21of. INJURY OCCURRED	
		21og. PLACE OF INJURY		21oh. INJURY OCCURRED	
		21oi. PLACE OF INJURY		21oj. INJURY OCCURRED	
		21ok. PLACE OF INJURY		21ol. INJURY OCCURRED	
		21om. PLACE OF INJURY		21on. INJURY OCCURRED	
		21oo. PLACE OF INJURY		21op. INJURY OCCURRED	
		21oq. PLACE OF INJURY		21or. INJURY OCCURRED	
		21os. PLACE OF INJURY		21ot. INJURY OCCURRED	
		21ou. PLACE OF INJURY		21ov. INJURY OCCURRED	
		21ow. PLACE OF INJURY		21ox. INJURY OCCURRED	
		21oy. PLACE OF INJURY		21oz. INJURY OCCURRED	
		21pa. PLACE OF INJURY</			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or has been checked, report any injury, or other traumatic event, the medical examiner must be notified before burial.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 1 8 8 4 2

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Charles Clinton FISHER			2a. DATE OF DEATH MONTH DAY YEAR July 22, 1983		2b. HOUR 10:15 ^A
3. SEX male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept 5 1913	6. AGE (IN YEARS LAST BIRTHDAY) 69	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama	8b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Calvert MD.		
10. CITY OR TOWN OF DEATH Prince Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN	12b. KIND OF BUSINESS OR INDUSTRY AUTOMOTIVE		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. NA Doole		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 6009 PARKER DR 20157		
14. FATHER'S NAME FIRST MIDDLE LAST Charles Fisher		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Haslip			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214 03 9747		17. INFORMANT ADDRESS Thelma Fisher #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Cardiogenic Shock / Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes 1-2 wks Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Severe Obesity / Complete Heart Block - pacemaker / Diabetes mell - II.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/22 19 83, to 7/22 19 83, that (I) (we) last saw the deceased alive on 7/22 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Gerald P. Sterner		DEGREE MD		22c. DATE SIGNED 7/22/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gerald P. Sterner, M.D.		22e. ADDRESS Owings, MD 20736			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 7-25-83		23c. NAME OF CEMETERY OR CREMATORY George Washington	
23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi PG MD		23e. DATE REC'D. BY REGISTRAR JUL 27 1983			
24. FUNERAL DIRECTOR NAME Hordey FH, 12 Ridge Ave Annapolis Md		25. REGISTRAR'S SIGNATURE John J. Conish			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 3 1 8 8 4 3							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Annie Caroline HALL						2a. DATE OF DEATH MONTH DAY YEAR July 16, 1983		2b. HOUR 6:35A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec 28 1915		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Calvert County MD.			
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD						13b. COUNTY Calvert		13c. CITY OR TOWN Chesapeake Beach	
14. FATHER'S NAME FIRST MIDDLE LAST John W Sturdivant		15. MOTHER'S MARRIED NAME FIRST MIDDLE LAST Sophie Collins		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) —		17. INFORMANT ADDRESS Conley W Hall same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) <u>Atherosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>old myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Recurrent Pulm. edema</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Diabetes Mellitus</u>									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>6-24</u> 19 <u>83</u> , to <u>7-16</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>7-15</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>M. P. Shah, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>7-16-83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MAHESH P. SHAH</u>				22e. ADDRESS <u>910 Calvert Mem. Hospital Prince Frederick, MD. 20678</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		July 19, 83		Southern Mem Gardens		Dunkirk Calvert MD			
24. FUNERAL DIRECTOR (NAME AND ADDRESS) <u>Rabach Funeral Home Owings MD</u>				25a. DATE REC'D. BY REGISTRAR IN REGISTRAR'S SIGNATURE <u>JUL 25 1983</u>					

BP

2025 CO-OM FILE

CHIEF JAIL



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Theodore Anthony Holland			2a. DATE KNOWN OF DEATH 7/5/83 19			2b. HOUR 2:15 P		
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH Dec. 11 1959	6. AGE (IN YEARS) 23 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	7c. DATE PRONOUNCED DEAD 7/5/83 19	9. BALTIMORE CITY OR COUNTY OF DEATH Calvert County MD.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Huntingtown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 2146 Wilson Rd. 20639
14. FATHER'S NAME FIRST MIDDLE LAST Wardell Holland		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST June Harrod						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 217-80-7370		17. INFORMANT ADDRESS June Holland 2146 Wilson Rd., Huntingtown				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9109 IMMEDIATE CAUSE (a) Drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:30AM 7/5/83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject drowned				
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) water		21f. LOCATION (CITY OR TOWN) Chesapeake Bay, South of Chesapeake Beach, Md.		COUNTY STATE Calvert, Md.		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER		DATE SIGNED 7/6/83	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 9, 1983		23c. NAME OF CEMETERY OR CREMATORY Bible Way Chr. Cem.		23d. LOCATION (CITY OR TOWN) COUNTY STATE Prince Frederick Calvert Md		
24. FUNERAL DIRECTOR NAME Spencer E. Sewell				ADDRESS Box 31, Prince Frederick, Md		25a. DATE REC'D. BY REGISTRAR JUL 11 1983		25b. REGISTRAR'S SIGNATURE



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				3		1 8 8 4 5	
1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Joshua NMN HUTCHINS				2a. DATE OF DEATH MONTH DAY YEAR July 19, 1983		2b. HOUR 1:02A M	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR Aug 28 1898		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Calvert MD	
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Huntingtown		13e. STREET ADDRESS Box 298, Stinnett Rd. 20639	
14. FATHER'S NAME FIRST MIDDLE LAST Julius Hutchins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Mackall			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214-14-4271		17. INFORMANT ADDRESS Lillian Hutchins Box 298, Huntingtown, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Metastasis 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Hypernephroma Left Kidney DUE TO, OR AS A CONSEQUENCE OF (c) 3 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): (1) Congestive Heart Failure (2) Bone Metastasis (3) COPD							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/17 , 19 83 , to 7/19 , 19 83 , that (I) (we) last saw the deceased alive on 7/18 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE ATMunshi				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anwar Munshi, M.D.				22e. ADDRESS Prince Frederick, MD 20678			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jul. 25, 83		23c. NAME OF CEMETERY OR CREMATORY Plum Point Chr. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Huntingtown Calvert Md	
24. FUNERAL DIRECTOR NAME Spencer E. Sewell				ADDRESS Box 31, Prince Frederick, Md		25a. DATE REC'D. BY REGISTRAR JUL 25 1983	
				25b. REGISTRAR'S SIGNATURE John J. Canfield			

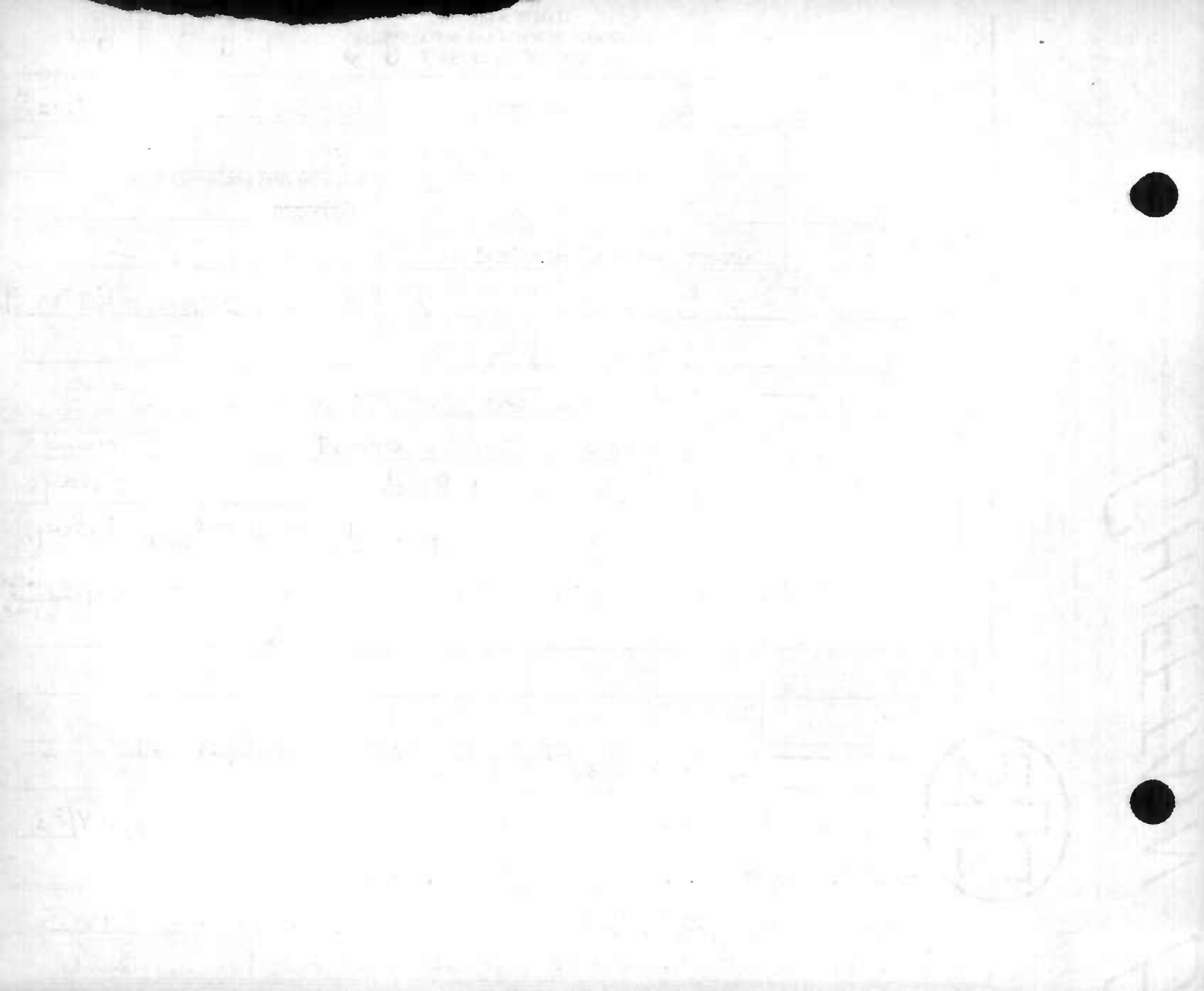
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										18846			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Ruth Jane MERRIMAN								July 24, 1983					1:02 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		white		DEC 29 1907		75		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Pennsylvania		USA				Calvert							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Prince Frederick		Calvert Memorial Hospital		housewife									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Calvert		Bundelord		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 201 Calverton Rd 20689					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
Perry B		Keith Anna											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		192 108 113		Donald Merriman		same apt #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) Asystole - Cardiac Arrest										Minutes			
DUE TO, OR AS A CONSEQUENCE OF (b) Complete Heart Block										2 days			
DUE TO, OR AS A CONSEQUENCE OF (c) Cardiopulmonary Arrest secondary to severe cerebrovascular accident										5 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
Diabetes Mell. II / Large Right Parietal Thrombotic Stroke with extension - herniation temporal													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION									
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (the hospital) attended the deceased from July 1, 1983, to July 24, 1983, that (I) (we) last saw the deceased alive on July 24, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
Gerald P. Sterner		MD				7/24/83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Gerald P. Sterner, M.D.		Owings, Maryland 20736											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Cremation		July 25, 83		Cedar Hill		Suitland PG MD							
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Raboch Funeral Home		JUL 28 1983		John J. Carver									



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Thomas DeSales MILES			2a. DATE OF DEATH MONTH DAY YEAR July 8, 1983			2b. HOUR 11:58 ^P			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Jan 18 1916		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Calvert MD.			
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retail Sales Gasoline		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY Calvert		13c. CITY OR TOWN North Beach		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 746 Walnut Ave 20714	
14. FATHER'S NAME FIRST MIDDLE LAST George T Miles					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary G Barbour				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1943-46 578 168321		17. INFORMANT Carrie Heckett		ADDRESS same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 2866 IMMEDIATE CAUSE (a) Disseminated Intravascular Coagulation DUE TO, OR AS A CONSEQUENCE OF (b) Septic Shock Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from July 8, 1983, to July 8, 1983, that (I) (we) last saw the deceased alive on July 8, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.									
22b. SIGNATURE Issam F. el-Damalouji						DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 7-9-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Issam F. el-Damalouji, M.D.					22e. ADDRESS Prince Frederick, Maryland 20678				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE July 12, 83		23c. NAME OF CEMETERY OR CREMATORY Heedburg Union		23d. LOCATION CITY OR TOWN COUNTY STATE Leesburg Loudoun Va		
24. FUNERAL DIRECTOR NAME Raboch Funeral Home					25. DATE REC'D. BY REGISTRAR JUL 18 1983				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 and 5 should be filed with the funeral director and completely filled in by the funeral director prior to burial, cremation, or removal. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

BP

DHMH - 16 50M 4/82
(VRA 15. 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

18848

1. DECEASED NAME (TYPE OR PRINT) Alice Mae H MOORE			2a. DATE OF DEATH MONTH DAY YEAR July 24, 1983			2b. HOUR P 2:16 M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 29 1912		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Calvert MD.	
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Clerk		12b. KIND OF BUSINESS OR INDUSTRY Accounting	
13a. STATE Maryland		13b. CITY OR TOWN Calvert		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS Box 245 Long Beach Drive 20685	
14. FATHER'S NAME FIRST MIDDLE LAST Norman Hardy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Grimes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> NO		16b. SOCIAL SECURITY NO. 220 506 216		17. INFORMANT James F Moore, same, do #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) obstruction to Aortic prosthesis (def). 4019 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prosthetic valve, Pul. Edema. (c) Heart My Perforation							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/23 19 83, to 7/23 19 83, that (I) (we) lost saw the deceased alive on 7/23 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Kioumarce Yazdani				DEGREE M.D.		22c. DATE SIGNED 7-24-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kioumarce Yazdani, M.D.				22e. ADDRESS Huntingtown, Maryland 20639			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE July 27, 83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland PG Maryland	
24. FUNERAL DIRECTOR NAME Raboch Funeral Home				25a. DATE REC'D. BY REGISTRAR JUL 28 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

EP-AS-7



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

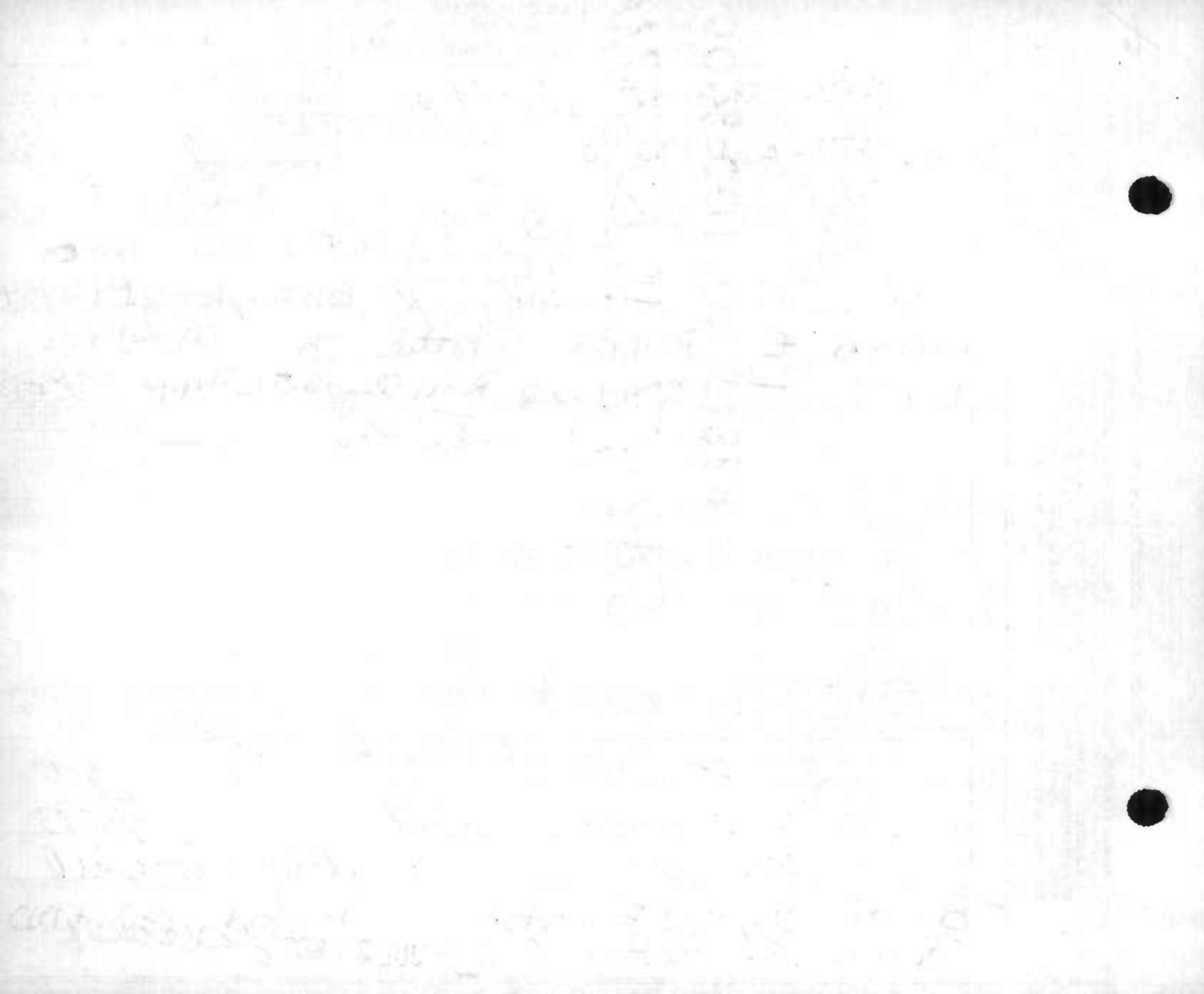
DHMH - 17
(VRA 15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 8 8 4 9
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>J M Ernest Phipps</i>						7a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <i>7 15 83</i>		7b. HOUR <i>1:15</i> M	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Aug 19 1912 70</i>		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. <i>70</i>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <i>7 15 83</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>		7b. CITIZENSHIP OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Calvert</i> MD.			
10. CITY OR TOWN OF DEATH <i>Pt Fred</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>C M H</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i> tobacco</i>	
13a. STATE <i>MD</i>						13b. COUNTY <i>Cal</i>		13c. CITY OR TOWN <i>Dunkirk</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William E Phipps</i>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Katie B Moreland</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>						16b. SOCIAL SECURITY NO. <i>214142612</i>		17. INFORMANT NAME ADDRESS <i>Ruth Elizabeth Phipps 3002 #13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic vas. disease</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>G. Weems</i>				TITLE (SPECIFY) <i>asst</i> M.D.		MEDICAL EXAMINER		DATE SIGNED <i>7/15/83</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>Weems</i>				ADDRESS <i>Huntingtown, MD</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>July 12, 83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Friendship</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Friendship Calvert MD</i>	
24. FUNERAL DIRECTOR NAME <i>Raboch Funeral Home</i>				ADDRESS <i>MD</i>		25a. DATE REC'D. BY REGISTRAR <i>JUL 21 1983</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Eva				2a. DATE OF DEATH MONTH DAY YEAR July 29, 1983			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 28 05		6. AGE (IN YEARS LAST BIRTHDAY) 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Calvert	
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Housework	
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Dunkirk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Casimir		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine		13e. STREET ADDRESS 10400 Three Doctors Rd. 20754			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-24-8189D		17. INFORMANT ADDRESS Kathleen T. Sliwka 10400 Three Doctors Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Arrest/Distress 4912 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Bronchitis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 78 hrs. years. years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Arterio-sclerotic Cardiovascular Disease / Angina pectoris / Myocardial Infarction History							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this health) attended the deceased from 7/29 , 19 83 , to 7/29 , 19 83 , that (I) (we) last saw the deceased alive on 7/29 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Gerald P. Sterner				DEGREE MD		22c. DATE SIGNED 7/29/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gerald P. Sterner, M.D.				22e. ADDRESS Owings, Maryland 20736			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-2-83		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Dundalk, Balto. Co., Md.	
24. FUNERAL DIRECTOR NAME Charles S. Zeiler & Son Inc.				25a. DATE REC'D. BY REGISTRAR AUG 01 1983			
ADDRESS 6224 Eastern Ave.				SIGNATURE John J. Gough			

BP

